25th Anniversary

Linacre Quarterly

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FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

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The Federation of Catholic Physicians' Guilds

The Linacre Quarterly

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In this Issue . . . . .

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JOHN J. FLANAGAN, S.J.
Editor

EDITORIAL OFFICE:
1438 South Grand Blvd.
St. Louis 4, Missouri

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President's Page

In the November, 1950 issue of *The American Journal of Obstetrics and Gynecology,* Frederick C. Irving, M.D. published a monograph on tubal sterilization. Dr. Irving had been my professor of obstetrics at Harvard Medical School. He was a gentleman intolerant of the beliefs of others. Interestingly enough, he waited until his retirement as professor and chief of obstetrics at the Boston Lying-In Hospital before he published this monograph devoted to the mechanics of ligating tubes. He concluded his article with: "For those curious about such matters, it is significant to note that in the entire series of 1,106 patients, 667 or 61.2% were of the Roman Catholic faith."

This article was brought to the attention of the Boston Guild of St. Luke. Through its chaplain, the article was passed to Chancery for a directive of action. A conference of clergy and doctors was called by the Chancellor. The conclusions reached were the following: 1) Contrary-wise, medical papers would be of little value where this paper dealt solely with the mechanical act of sterilization and not with indications. 2) Public discussions might inversely advertise the hospital and doctor. 3) The most effective measure would be to offer Catholic patients far better facilities under Catholic auspices and thereby attract the case-load away from institutions intolerant of Catholic beliefs.

Forthwith, Archbishop Richard J. Cushing announced the plan of converting one of the less adequate general hospitals of the archdiocese into a Maternity Center. Steps were taken also to improve St. Elizabeth Hospital's maternity wing. The staff conversion and hospital reconstruction were time consuming but effective. In 1957, St. Margaret's Hospital delivered *4,052* babies, in contrast to *2,098* in 1950. This, added to the increase in the other Catholic facility — St. Elizabeth's — *2,036* in 1950 to *3,616* in 1957, totals 7,668 deliveries under Catholic auspices.

This report is made to answer nationally the published allegation of November 1950 and to emphasize, again, that Catholic Action in medicine is most necessary and can be most fruitful.

WILLIAM J. EGAN, M.D.

25th Anniversary

A quarter of a century may not seem a large segment of time, but it takes on that proportion when reviewing the labors of those years. That "the pen is mightier than the sword" has always been the fond hope of those responsible for the publishing of THE LINACRE QUARTERLY and will continue as the official journal of The Federation of Catholic Physicians' Guilds begins its 25th year of publication.

In 1932, the officers of the Federation felt there should be an official organ to represent the principles of the organization. Dr. James J. Walsh of New York, an early and very important contributor, suggested that the journal be named for Thomas Linacre who founded the Royal College of Physicians and through it influenced the practice of medicine. There was agreement, and the first issue appeared in December. (Incidentally, that first number indicated the proper pronunciation of the name to be as though it were "Linn-eh-ker," accenting the first syllable — to answer the question we are often asked regarding this.)

Oftentimes, under great stress and sacrifice, publication was continued through 1945. Because of change in editors and place of publishing, it was necessary to omit issues in 1946. Publication was resumed in 1947.

Dr. Anthony Bassler was the first editor. To make it truly a journal of the philosophy and ethics of medicine was no easy task in those early years. Then, as now, the continual effort to secure articles geared especially to the needs of its readers, presented a challenge. To present timely material concerning the philosophy and ethics of medical practice in the light of Catholic teaching has ever been the aim of the journal's editorial staff. The struggle for survival is recounted in the early issues and the loyal efforts of Dr. Bassler and his associates deserve high praise. Dr. and Mrs. Joseph A. Dillon with Dr. James J. Walsh also helped to steer the course during those early years. The guiding hand of Father Ignatius Cox, S.J., was a mainstay during that period.

With the transfer of publication to St. Louis, Missouri in 1945, Father Alphonse M. Schwitalla, S.J. was asked to become editor. Along with many other duties, he served most ably, writing much himself, until 1947 when, because of ill-health, he was unable to continue in this capacity. In 1948 Father John J. Flanagan, S.J., became editor.

The many excellent contributions of Catholic physicians to the journal through the years are too numerous to mention by title here. The high-principled presentations are well worth a second study, now that we are reaching back over this quarter-century. A review of back issues reveals a surprising similarity in problems discussed in those early issues and those considered today. The same moral issues apparently need continued scrutiny.

No retrospection of this kind would be complete without a profound tribute to those who speak for the Church in matters of medico-moral consideration. Our Holy Father, Pope Pius XII, has spoken on many matters of concern to the medical profession and his words have appeared frequently in THE LINACRE QUARTERLY.

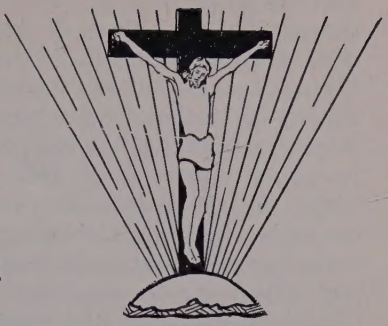
And the moral theologians without whose help this journal might have become just another pious publication have contributed the most outstanding works to be included in the issues. To Father Gerald Kelly, S.J., whose great interest in medico-moral issues prompted his many writings in behalf of the medical profession. THE LINACRE QUARTERLY expresses the deepest gratitude. His outstanding contributions over the past ten years were the "life line" of many issues; always willing, despite a heavy teaching schedule at St. Mary's College in Kansas, he never refused a request for help, either to prepare an article or give advice in matters of medico-moral import. Our appreciation knows no bounds.

Another good friend, associated during the past five years, is Father John J. Lynch, S.J., whose articles have added great worth to the journal and who, too, gives assistance unstintingly in medico-moral matters. He also has a teaching schedule, at Weston College, in Massachusetts, but we can count on his generous help.

THE LINACRE QUARTERLY is now serving seventy Catholic Physicians' Guilds throughout the United States and Canada and Puerto Rico and subscriptions total nearly 9,000. With a rededication of purpose, effort will be put forth to uphold the principles of the Federation of Catholic Physicians' Guilds and continue to publish material that will give moral guidance to those who need it to become better Catholics in their practice of medicine.

THE MEDICAL ASPECTS OF THE CRUCIFIXION OF OUR LORD JESUS CHRIST

From a Study of the Shroud of Turin



Robert Bucklin, M.D., F.A.C.P.

TO A physician, a study of the Passion and death of Christ presents an intriguing consideration. Unfortunately, relatively few individuals with a medical background have undertaken this investigation.

A detailed review of the situation and events leading to the Passion and death of Christ are not within the scope of this paper. However, it is necessary that a certain amount of background material be presented for general orientation. To one entering upon this field of research, it is vitally important that there be careful separation of what is fact from what is fancy or fiction. There are many positive facts about the Crucifixion which are well documented. The date, for example, has been established beyond reasonable doubt to have been April 7, 30 A.D. The site of the Crucifixion was the hill named Golgotha, a short distance from the north wall of the city of Jerusalem. Through a study of the New Testament and with the aid of archeological revelation, it is possible to trace the footsteps of Christ with a high degree of accuracy for the last few hours of His life.

After the establishment of the Holy Eucharist with the disciples at the Cenacle on Thursday evening, Christ and some of His disciples left the city and proceeded in a northeasterly direction to the Garden of Gethsemane, passing through the old Fountain Gate in the south end of the city and walking along the Valley of the Cedron. It was in the Garden that the Passion really began, and here it is that Christ suffered the bloody sweat. Such a phenomenon is exceedingly rare but is explained by hemorrhages into the sweat glands occurring at this time, as the result of a highly emotional state. The amount of blood lost is, of course, unknown, but it can probably be assumed on the basis of events which followed that the amount was small. No comment is made in the Scripture about there being saturation of garments.

Before the party left the Garden of Olives to proceed back to Jerusalem, Christ was arrested by the soldiers of the high priest and taken to the courtyard of the home

of Caiphas, which was located in the southwest portion of Jerusalem, not far from the Cenacle. Here it is that the trial took place during which time Christ was subjected to a number of indignities, including blows about His face. Since the Sanhedrin, the Jewish governing body, did not have the authority to put the death sentence into effect, it was necessary that Christ be taken to the court of Pontius Pilate, the Roman governor, in order that the death sentence be confirmed. Pilate held court at the Antonia which was a fortress-like structure at the north end of the Jewish temple.

The events which transpired as the result of orders by Pilate are well documented in the Gospels. These included the scourging and the crowning with thorns. At one time, either as the result of an attempt at courtesy or one of derision, Christ was taken to the palace of Herod Antipas at the request of Pilate. Christ refused to answer any of Herod's questions and was promptly returned to the Antonia. The death sentence having been confirmed, crucifixion was ordered, and the Victim was given a portion of His cross to carry. The distance actually traversed by Christ with His cross was approximately 600 yards. During that distance, tradition tells us of several falls, and as a result bruises and abrasions were sustained in various portions of the body. The time consumed by the transporting of the cross to Calvary was probably fairly short. Since crucifixion was a common method of carrying out the death penalty, it can be assumed that the soldiers who performed the nailing and suspension of the Victim onto the cross were experienced in their duties, and that this portion of the process was done quickly.

Scripture tells us that Christ was suspended on the cross for approximately three hours, and that He expired at about 3 o'clock in the afternoon. There is reason to believe that death occurred more quickly than might have been expected. The statements of Pilate would support this contention, when he was asked by the disciples for permission to remove the body from the cross. Probably not much thought had been given to what was to be done with the body after removal from the cross, until the actual time of death. Since the following day was the Sabbath and in this particular year was also the Passover, it was a day which was doubly holy, and according to the Jewish law no work was permitted on that day. The burial of a body was considered as labor. The Sabbath officially began at sundown on Friday, so that it was necessary for any burial procedure to be completed prior to that time.

Because of the short period, it was not possible for the disciples to perform the usual burial ritual which included anointing the body carefully with warm scented water and oils before placing it in the sepulchre. All that there was time to do was to wrap the body quickly in the long linen cloth which was brought to the scene by Joseph of Arimathea and to place within the folds of the cloth and on the body a mixture of aloes and

myrrh to serve as a preservative. St. John states in his Gospel that approximately sixty-five pounds of this preservative were used. The body was laid upon the cloth in a linear fashion, and the cloth was folded over the front portion of the body. The arms were placed over the chest, rigor mortis having been broken in order to accomplish this. A narrow band was placed around the chin and over the top of the head in order to keep the jaw in place. The body was then transported a short distance to the sepulchre. Whether the sepulchre was actually a cave-like structure or whether it was a shallow grave is not known. Most evidence, however, points to the fact that it was in the form of a small chamber slightly over 2 meters in its largest dimension.

The body lay in the sepulchre for an unknown period of time and was gone from the place early on Sunday morning when the burial party returned. At that time only the wrapping cloths were found in the sepulchre. The long linen cloth in which the body was wrapped has been preserved through the centuries, and it is this cloth which is known today as the "Shroud of Turin." Its history is colorful and has been traced in detail by a number of European authors. On occasion it has been damaged by fire, and visible on it are several paired patched, put on to cover holes burned in the cloth. There is no serious question about its authenticity. The Shroud is preserved at the present time in the Cathedral in Turin, Italy. The cloth is remarkable because on it there is imprinted an image of a human body showing both frontal and dorsal views. Present also on the cloth are blood stains, marks left by fire, and some large water stains. Photographs of the cloth were taken in 1898 by Secondo Pia and in 1931 by Guiseppie Enrie. The photographs of Enrie are remarkable in their clarity, and it is a study of these photographs, including life-sized enlargements, which are the basis for the medical study of the events of the crucifixion.

A consideration of the medical phases of the crucifixion properly begins with a careful examination of the frontal and dorsal imprints appearing on the Shroud of Turin. The cause of these imprints has been examined by a number of investigators, and it can only be stated that at the present time there is no clear explanation for their presence. The imprints outline the body of an adult male, seventy-one inches in height and weighing an estimated one-hundred seventy-five pounds. The stiffness of the extremities in their imprints is strongly suggestive that rigor mortis had taken place. On the image there are evidences of a number of injuries. Each of these injuries has produced a characteristic imprint. Those which reflect abrasions and contusions have left imprints which are characteristic of this type of injury. Those which have resulted from the outflow of blood from large cavities have left their imprints in an equally characteristic fashion. This is particularly true of a large imprint of blood appearing on the frontal image of

the chest. It is immediately apparent to the investigator that the image on the Shroud is in effect a mirror image with right and left reversed. This is easily explained by the position of the cloth above and below the body during its tenure in the sepulchre.

The injuries to the body can be well divided into five groups: the marks of the scourge; the nail imprints in the wrists; the nail marks in the feet; the wounds on the head, and the wound in the chest. The marks of the scourge appear on the front and back of the body and are most notable over the back. Here they extend from the shoulders down as far as the calves of the legs. On the front of the body they also appear on the chest and legs, but there is no evidence of marks of the scourge appearing on the arms or forearms. From this fact it may be assumed that the arms were elevated over the head at the time of the scourging. The scourging was done as a preliminary to the crucifixion, and we are told by historians that it was a common event. The implement used was a whip-like structure called a flagrum. It consisted of two or three thongs, at the ends of which were tied small bits of either bone or metal. The implement was applied to the body in such a way as to produce bleeding by the metal or bone tearing the skin. The marks, as they appear on the Shroud image, clearly define the shape of the tip of the flagrum. It is notable that the imprints of the scourge appear in a sheaf-like fashion directed downward and medially from the shoulders. Their appearance would serve to indicate that there were either two persons doing the scourging or that one scourger changed his position from the right to the left side. The number of scourge marks is particularly interesting. It was the Jewish law that the scourging would be limited to forty blows, and, as a matter of habit, the limit was practically set at thirty-nine. Scourging under the Roman law, as occurred in the case of Christ, was unlimited in its extent. Those who have counted the scourge-mark images on the Shroud have variously estimated them as up to or more than one-hundred.

From an examination of the imprint of the back, it may be possible to draw some conclusions as to the structure and manner of carrying the cross. Most of our religious paintings and pictures show Christ carrying His entire cross, supported over one shoulder. It is highly improbable that such was the actual situation. In the first place, if the cross were made according to what we are told was the manner of the times, it would have been an extremely heavy structure, variously estimated to have weighed nearly three-hundred pounds. It is highly improbable that anyone could have carried this weight even for six-hundred yards. As a matter of fact, since crucifixion was a common method of putting victims to death, the upright portion of the cross, known as the *stipes*, was permanently in place at the point of execution. It was a long beam firmly embedded in the ground and extending up for about eight feet. The crossbar or *patibulum* was the

portion carried by the victim. The weight of the crosspiece is unknown but has been estimated to weigh as much as eighty pounds. The manner in which the *patibulum* was supported on the body appears fairly definite by examination of the imprints on the back of the image. Had the crossbar been carried over one shoulder, it could reasonably be expected that it would have produced a large bruise on the shoulder. Since all the other bruises suffered by Christ during His passion have appeared so distinctly on the Shroud image, one wonders why there is no evidence of a bruise on the shou'der. However, examination of the back in the region of the *scapulae* shows two large areas of bruising. These might have been produced by the crossbar being supported over the upper portion of the back rather than being balanced on one shoulder. A weight thus supported is actually easier to carry, since its weight is divided over a large area. Another explanation for these bruises might be the writhing of the victim while suspended on the cross.

Examination of imprints left by the hands and arms of Our Lord provides a great deal of information, and here again it becomes immediately apparent that the position of the nails as ordinarily depicted is subject to some question. The hands, as they appear on the imprint, show the marks of four fingers well. There is, however, no evidence of imprints left by the thumbs. The hands are crossed, with the left hand appearing on top of the right and covering the right wrist. In the region of the left wrist, there is a blood-stain which represents the mark left by the nail. That this mark is not in the palm is easily ascertained by simple measurements taken from the site of the mark to the tips of the fingers. It becomes readily obvious that the mark is not in the center of the palm, but in the wrist. The mark left by the nail in the right wrist is covered by the left hand.

The careful experiments of Dr. Pierre Barbet in Paris have served to prove without doubt that a nail passed directly through the palm could not support a body weighing 175 pounds. There is insufficient tissue between the metacarpal bones of the palm to adequately support a nail, and, as Barbet was able to prove, the nail would quickly tear through the soft tissues and skin and fail to support the body. A nail, however, placed through the carpal bones and supported by the bones and by the ligaments of the wrist was proved adequate to sustain the weight of a body satisfactorily. There are some who feel that the nail was placed higher than the wrist, between the radius and ulna. It is true that such a placing would be done easily, but it also appears that there is insufficient space between the radius and ulna near the wrist to allow a nail to enter. The position of the nail still remains a point of minor controversy, although the great weight of evidence indicates that it was placed through the carpal bones, which it separated but did not fracture. The blood-stain on the left wrist is composed of two

projecting stains which are separated from one another by approximately a 10 degree angle. This angulation is an evidence of the fact that the body while suspended on the cross assumed two different positions in such a way that the blood running from the nail hole in the wrist proceeded in two slightly divergent streams. This fact is further supported by examination and measurement of the angles of flow of the blood streams on the forearms. Each of these blood streams on the image appears to extend almost horizontally. If one were able to extend the arms laterally until the blood streams appear vertical, it would be found that they are extended in a position approximately 65 degrees from the horizontal.

From the positions of the streams of blood both on the wrist and on the forearm, it is obvious that there must have been some other support for the body besides the nails in the wrists. The author was privileged to observe the suspension of a human on a cross in the studio of Reverend Peter Weyland, S.V.D. and also to suspend himself for a brief period of time under the direction of Father Weyland. The pain suffered by a suspension by the wrists alone is all but unbearable, with the tensions and strains being directed to the deltoid and pectoral muscles. These muscles promptly assume a state of spasm, and the victim so suspended is physically unable to make use of his thoracic muscles of respiration. However, as soon as a support is provided for the feet, the suspended victim is immediately able to relieve the strain on his wrists and to direct his weight toward his feet. By so doing, he elevates his body to a slight degree by extension of his legs. This change in position is of approximately 10 degrees and readily accounts for the divergence in the streams of blood as they pass down the wrists and forearms on the Shroud image. The fact that on the imprint of the hands no thumb is visible is explained by the fact that the nail passing through the bones of the wrist either penetrated or stimulated the median nerve. The motor function of the median nerve is flexion of the thumb; the thumb being flexed over the palm remained in that position after rigor mortis was established and for that reason does not appear on the hand imprint. Some slight suggestion of the pain suffered by a suspended victim with a nail through or near his median nerve is possible when one realizes that the median nerve is a sensory as well as a motor nerve.

A study of the imprints of the feet is somewhat less complicated than the study of those of the arms and hands. On the Shroud there are two prints representing the marks left by blood-covered feet. One of these, the mark of the right foot, is a nearly complete footprint on which the imprint of the heel and the toes can be seen clearly. In the center of this is a square mark surrounded by a pale halo and representing the position of the nail in the foot. The imprint made by the left foot is considerably less clear and does not in any way resemble a footprint. Examination

of the calves of the legs on the dorsal view shows that the right calf has left a well-defined imprint on which the marks of the scourge can be well seen. The imprint of the left calf is considerably less distinct, and this, coupled with the fact that the left heel is elevated above the right heel, leads to the conclusion that there is some degree of flexion of the left leg at the knee, and that the occurrence of rigor mortis has left the leg in this position. It appears, then, that the right foot was directly against the wood of the cross, and that the left leg was flexed slightly at the knee and the foot rotated so that the left foot rested on the instep of the right foot. By this position, the blood on the soles is accounted for readily. A single nail was then used to fix both feet in position. Whether or not there was any other support for the feet than the wood of the cross has been a matter of some conjecture, and up to the present time the point cannot be settled. The reason for the nailing of the feet was twofold: the simplest reason was to prevent the victim from flaying his legs about, but the second reason was more *thoughtful* and was based upon the fact that a victim supported only by his wrists was unable to survive for more than a very short period of time; by having some kind of foot support, he was able to alternate his position so that his agony could be prolonged for a much greater period of time. This fact becomes obvious when one positions himself on a cross suspended by his wrists alone.

The marks on the head constitute the third group of injuries. On the front of the face, in the forehead, there are several blood prints. One of these has assumed the appearance of a figure 3. On the back of the head, circling the scalp, is a similar row of blood prints. These were obviously left by the crown of thorns. High on the scalp are similar blood stains which can be explained if one assumes that the crown of thorns, instead of a circlet, was shaped more like a cap and that there were branches and thorns laced over the top of the cap. We are told that the thorns were approximately one inch in length. Passing through the skin and subcutaneous tissues of the scalp, they lacerated vessels and, as is well known of scalp injuries, there was a considerable amount of bleeding because of the retraction of the torn vessels. On the face, corresponding to the right cheek, there is a swelling of the malar region. This has resulted in partial closure of the right eye. Presumably this injury occurred during the time of the trial in the courtyard of Caiphas, when it is recorded that Christ was struck in the face by one of the soldiers. There is a very slight deviation of the nose, and some who have examined this image have stated that there is a fracture of the nasal cartilage. At the tip of the nose there is a bruise which probably occurred during one of the falls while carrying the cross. A small moustache is readily visible on the upper lip, and covering the chin is a short beard which is divided into two portions. The straightness of the sides of the face and the short separation of the locks of hair from the face are

readily accounted for by a chin band which was placed around the jaw and over the top of the head.

The last of the major wounds on the body of Christ is that in the side. It is obvious that this wound, which was made by the lance after the death of our Lord, is on the right side. It is partly obliterated by one of the several patches on the cloth, but its imprint is still clear. This imprint of blood shows the effects of gravity and actual drips and droplets of blood are clearly seen. There is also evidence of separation of clot from serum. At this point, and also more clearly seen on the dorsal imprint near the lower portion of the back, there is evidence of another fluid which has been mingled with blood. Recalling the words of the Gospel of St. John, we are told that after the lance pierced the side of Christ, there was an outflow of blood and water. It appears that the source of the blood cannot be seriously questioned. It must have come from the heart, and from the position of the blood imprint as well as its structure it can be assumed that this blood came from the right side of the heart. This chamber was dilated after death and when pierced by the lance, the blood readily flowed from it. A considerable portion of the blood must have dripped onto the ground, but enough was left to form a large stain on the chest and to be later transferred to the Shroud. The source of the water described by John presents more controversy. The theory presented by Dr. Barbet was that the fluid represented pericardial fluid. However, the amount of pericardial fluid normally present is in the nature of 20 to 30 cubic centimeters, too small an amount to be seen by the naked eye as it came out of the wound in the side with the blood from the heart.

Dr. A. F. Sava has presented a challenging theory that there was a hydrohemothorax caused by the trauma to the chest by the scourging and increased by the position of the body on the cross prior to death. Dr. Sava suggests that there was a separation of the blood and the watery fluid after death and the lance piercing the side released first the blood and then the clear fluid. It would appear that perhaps the combination of the theories of Barbet and Sava might explain the situation. An accumulation of fluid in the pleural space without hemorrhage is a logical conclusion as the result of congestive heart failure related to the position of the Victim on the cross. It is quite possible that there was a considerable amount of fluid so accumulated, enough so that when the lance pierced the side that fluid would be clearly seen. I feel that an actual puncture of the heart must be accepted as factual, particularly in view of recent statements by Pope Pius XII. If the theory of pleural effusion plus puncture of the right side of the heart were sustained, it would be expected that the water would have been visible from the side before the blood and that John's words would have appeared as "water and blood" rather than "blood and water." As a matter

of interest, the words appear in the former sequence in several of the early Greek translations of the New Testament. This point is still in controversy and may be settled by experiments which are currently being performed. When the body was removed from the cross and placed in a horizontal position, there was a second large outflow of blood from the wound in the side. Much of this must have fallen onto the ground, but some stayed on the body and flowed around the right side, leaving a large imprint of clot and serum in the lumbar area. It is in this imprint where the mixture of the blood and the watery fluid is best seen and its presence on the back lends further support to the theory that there was a pleural effusion rather than the water having come from the pericardial sac.

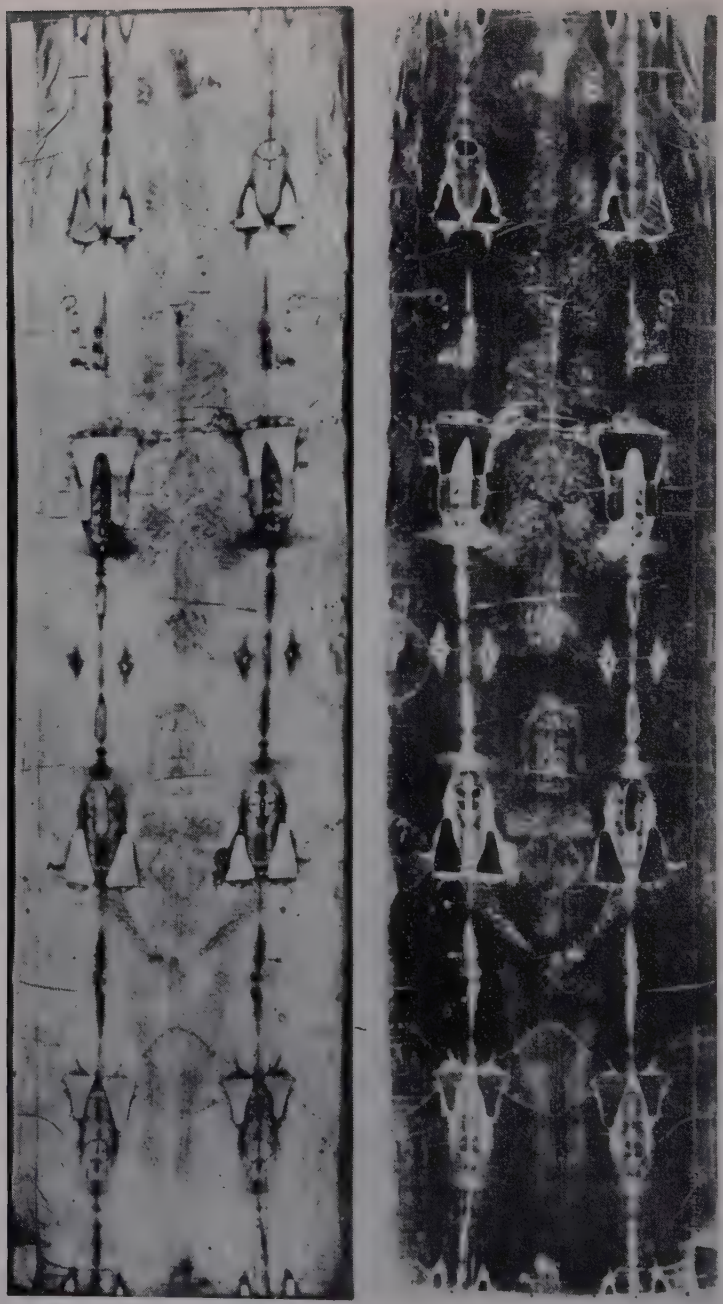
In this presentation, I have made no attempt to explain all of the marks as they appear on the Shroud of Turin. I make no claim for originality except in certain minor details. I am indebted to the many authors whose works will stand as monuments to their interest and efforts. These include Pierre Barbet, M.D.; Rev. Werner Bulst, S.J.; Rev. Francis Filas, S.J.; Rev. Adam J. Otterbein, C.SS.R.; Anthony Sava, M.D.; Paul Vignon; Rev. Peter Weyland, S.V.D.; Rev. Edward Wuenschel, C.SS.R., and others.

I have made no effort to comment upon the spiritual benefits of such a study. However, those who choose to look at the subject from that point of view will find much material for worthwhile meditation.

Dr. Bucklin is pathologist and Director of Laboratories, Saginaw General Hospital, Saginaw, Mich.

The Catholic Physician, does not have any special medical knowledge because he is a Catholic, but he does have a point of view from which to consider the problems of his profession. Therefore, he should try to exert a positive influence on his environment, especially when he works in non-Catholic surroundings.

Pope Pius XII. Radio message to the Seventh International Congress of Catholic Doctors, the Hague, September, 1956



POSITIVE AND NEGATIVE PHOTOGRAPHS OF THE SHROUD OF TURIN

PSYCHOSURGERY

Gerald Kelly, S.J.

Professor of Moral Theology, St. Mary's College, St. Marys, Kansas

The following is another chapter of the revised *Medico-Moral Problems* book of Father Gerald Kelly, S.J., being published by The Catholic Hospital Association. Permission has been granted to give this preview of material concerning psychosurgery. Many of the book's chapters begin with a quotation of directives which are observed in the operation of Catholic hospitals, included in the publication, *Ethical and Religious Directives for Catholic Hospitals. Directive 44* which is the basis for Father Kelly's considerations of the treatment of mental illness and pain provides the introduction to his discussion.

Lobotomy and similar operations are morally justifiable when medically indicated as the proper treatment of serious mental illness or of intractable pain. In each case the welfare of the patient himself, considered as a person, must be the determining factor. These operations are not justifiable when less extreme remedies are reasonably available or in cases in which the probability of harm to the patient outweighs the hope of benefit for him. (Directive 44, Cf. Canadian Code Art. 41, U. S. Code, "Other Special Directives," n. 2)

By psychosurgery I mean cerebral surgery employed for the purpose of treating mental illness and pain. In the booklets on medico-moral problems there were four discussions of psychosurgery.[1] It is hardly necessary to incorporate all that material into the present chapter of the revised *Medico-Moral Problems*. It seems better to give here merely a commentary on directive 44, so that all will know its meaning. In this commentary, I shall say something about: (1) the operations; (2) indications; (3) effects; (4) medical evaluation of the individual case; (5) consultation; (6) permission; and (7) the moral decision.

1. THE OPERATIONS

The first successful psychosurgical operation was performed by two Portuguese physicians, Egaz Moniz and Almeida Lima. The operation was a prefrontal lobotomy, which consists essentially in severing the white nerve fibers connecting the frontal lobes of the brain with the thalamus. The Portuguese doctors accomplished this by making two small holes in the skull, one at each temple, and inserting a dull, rounded knife called a leucotome. Because this operation could not be performed under direct vision, it is often called a "closed" lobotomy; and, because of the instrument used, the operation has been designated a leucotomy.

[1] These were: "Lobotomy," "More about Lobotomy," "Lobotomy for Pain Relief," and "Pope Pius XII and Psychosurgery"—which were published in booklets I, II, III, and V, respectively. The original articles are in *Hospital Progress:* Dec., 1948, pp. 427-428; Aug. 1949, pp. 254-256; Feb., 1950, pp. 56-57; and Feb., 1954, p. 66.

Since the original operation, there have been many variations of technique. There is "open" lobotomy, in which enough of the skull is removed to allow for operating under direct vision. There is a transorbital lobotomy, in which a sharp instrument that looks very much like an ice pick is inserted along the nose and through the eye socket and the fibers are thus cut from below. Still another variation is "coagulation" lobotomy, which is accomplished by inserting insulated electrodes into the frontal lobes from above. And there are, as every physician knows, numerous other procedures: for instance, lobectomy and topectomy, which consist in removing parts of the brain substance; thalomotomy, in which a wire electrode is passed down into the thalamus and a small portion of this part of the brain is coagulated; and selective cortical undercutting, which involves cutting the white fibers in one of the main areas of the frontal lobes. Finally, there is the growing tendency to restrict formerly extensive operations by doing only a partial cutting, e.g., unilateral instead of bilateral lobotomy.

The foregoing may not be a complete list of psychosurgical procedures; but they are the operations most frequently mentioned in the literature. Each operation has its defenders and its critics. The obvious purpose of directive 44 is to take no sides in a controversy over techniques but simply to give the general rule that, granted the conditions outlined in the directive, any of the techniques may be used. As for the choice of technique in an individual case, a good working rule is enunciated by Fr. Thomas J. O'Donnell, S.J., as follows: "The only moral directive here is that the surgeon select that method which he considers safest in his hands and in the best interests of the patient."[2]

2. INDICATIONS

The directive gives only the very general indications for psychosurgery: namely, serious mental illness and intractable pain. The main reason, of course, for keeping to a general statement was the need of brevity. Yet, even if space allowed for a development of these points, it would not be wise to enumerate specific indications for the operations in a directive. As is the case regarding the operative techniques, there are differences of opinion among specialists concerning the precise indications for psychosurgery. For instance, some would limit it to psychoses; many others would extend it to certain forms of neurosis. The directive simply requires that the mental illness be serious: that is, an illness which is chronic and truly disabling. Granted this, and granted the other conditions to be explained later, the directive would allow the operation for mental illness, regardless of the technical classification of the illness.

As regards pain, the cases considered intractable in the sense of the directive would be great and unbearable sufferings complicated by an anxiety state that makes them similar to a mental illness.

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[2] *Morals in Medicine* (Westminster, Md.: The Newman Press, 1956), p. 88.

Even though the directive is purposely phrased in a general way, there seems to be no objection to citing some of the statements of specialists concerning the indications for psychosurgery. I cite these, however, merely as illustrations and not as qualifications of the meaning of the directive. For instance, one doctor, writing in 1949, had this to say:

Today most observers see the best outlook for prefrontal lobotomy in long-standing depressive illnesses, particularly the involutional type, and in incapacitating obsessive-compulsive neuroses. Also, certain schizophrenic patients, especially the catatonic subgroup, have benefited from the operation. Contraindications for lobotomy are present when the emotional tone has become chronically flattened (the operation would only "flatten" it all the more); and the advisability of operation is also questionable in those cases where antisocial traits were evident in the previous personality.[3]

Two years later (in 1951) another specialist, after having described the effects of lobotomy in certain cases of mental illness, concluded:

It is considerations such as these which convince us that leucotomy is morally permissible in cases of serious psychasthenia, schizophrenia, and morbid attacks of depressive anxiety, provided these patients cannot be cured in some other way.

On the other hand, we do not consider that leucotomy is permissible in psychopathic cases where the structure of the personality reveals, on serious examination, no still healthy core on which to work. In this connection, we are thinking of certain groups of psychopaths who, as we know from experience, are completely lacking in any development of the emotions, intelligence and will, beyond the sphere of simple essential relations. Leucotomy cannot achieve its purpose with such individuals, psychically ill-developed and deformed, because the faculties which the intervention aims at liberating are completely faulty.[4]

[3] C. Charles Burlingame, M.D., "Psychosurgery — New Help for the Mentally Ill," *The Scientific Monthly*, Feb., 1949, pp. 140-144; words quoted are on p. 142.

Another, and more general, statement of the indication for psychosurgery, is that "it presupposes that the brain of the patient remains more or less intact, and that as a result of delusions, hallucinations, or obsessions, the mental tension is such that the patient cannot carry on a normal life."[5] And, as a final sample of this interesting literature, let me quote this paragraph:

Our patients are selected for lobotomy only after a thorough evaluation of the factor of anxiety, regardless of the clinical diagnosis. The beneficial effects of any type of prefrontal lobotomy are to be explained solely in terms of release of tension generated by repression. The chief symptom of such tension is anxiety in all its undisguised forms, such as guilt, self-condemnation, self-punishment, and fear, and in its masked forms such as phobias, obsessions, compulsions, hallucinations and delusions, hostility, and aggression. In this connection, it is well to remember that hypomanic and manic behavior is frequently a cloak for anxiety and in such instances represents a masked form of anxiety. If the symptoms of tension with resulting anxiety are prominent in a psychotic or neurotic patient, a varying measure of relief may be expected from lobotomy. The converse is also true, the less the anxiety the poorer the therapeutic result. Patients should then be selected on the basis of the anxiety symptom and the results of lobotomy appraised in terms of relief of anxiety and tension, rather than by the percentage of so-called remissions or cures in various diagnostic categories.[6]

[4] Prof. J. J. G. Prick, in *The Ethics of Brain Surgery* (Chicago: Henry Regnery Company, 1955), p. 28. The articles translated in this book originally appeared in *Cahiers Laënnec*, Mar., 1951.

[5] Quoted from *The Transactions of the Catholic Medical Guild of St. Luke* (Australia), Jan. 1954. This number of *The Transactions* contains a symposium on leucotomy held at Sancta Sophia College, University of Sydney, Mar. 1, 1953. The symposium covers pp. 19-42. The statement quoted in my text is by Dr. S. J. Minogue, p. 37.

[6] Howard D. McIntyre, M.D., Frank H. Mayfield, M.D., and Aurelia P. McIntyre, M.D., "Ventromedial Quadrant Coagula-

3. EFFECTS

As regards mental illness, the principal good effect of psychosurgery is relief from emotional tension: for example, a patient may be relieved from a crippling anxiety and, with proper help, may begin to lead a more or less normal life. Just how this relief is brought about has been and still is a matter of speculation. One explanation often accepted as very probable is that psychosurgery effects a sort of divorce between cognition and emotional response. In other words — to use an example — a thought or suggestion which might have caused the patient a veritable panic before the operation would scarcely trouble him after the operation.

There is a heavy price to pay for the desired release from tension. According to various specialists, psychosurgery induces personality changes of many kinds. For instance, here are some of the changes observed: inertia, lack of ambition and initiative, a tendency to be satisfied with little or no work or with work of a very inferior quality, lack of human-respect, some degree of moral degeneration, reduced capacity for prolonged attention, inferior planning ability, impairment of creative ability, lack of foresight and concern for the future, tactlessness, crude social behavior, lessening of affection, fatigue and excessive sleep, indifference to pain. To these personality changes may be added such things as failure to control toilet habits, and the risks of brain surgery in terms of mortality rate. Estimates of mortality rate vary somewhat, but, with some qualifications according to techniques, 2% to 3% is often given.

At first glance, this seems to be a grim picture, and one might easily conclude that psychosurgery does more harm than good. There are, however, some mitigating factors. For one thing, not all these effects are noticed in the same person. Also, there are degrees: some changes are very slight. Moreover, it is possible to preclude or avoid many of them by proper postoperative care. Furthermore, a careful selection of patients will avoid some of the worst effects; e.g., the probability of immoral acts and of antisocial behavior. Finally, there is the plain fact that, despite the unjustifiable experimentation that has sometimes been carried on in this field, the overall picture is that at least half the patients have been improved by the operations, and of the others, comparatively few were made worse. When patients are carefully selected, the operations properly performed, and postoperative care is properly given, the percentage of success is much greater.

It must be remembered that "improvement" both in mental cases and in cases of intractable pain must be measured in terms of the morbid state and not in terms of the premorbid personality. Precisely for this reason, some of the effects of psychosurgery that may be undesirable in themselves and for normal persons, may be actually good for those who are mentally ill or distraught with pain. I

tion in the Treatment of the Psychoses and Neuroses," *American Journal of Psychiatry*, Aug., 1954, pp. 112-119; see p. 119.

might illustrate this by a few citations from conscientious specialists. The first quotation concerns a woman patient, with generalized metastases from carcinoma of the rectum. The other two quotations concern mental patients in general. I shall merely give the quotations here, reserving comment to the next section:

The extreme pain, anxiety and despair were not controlled by a total of 122 grains of morphine, 70 grains of luminal and 12 ampules of cobra venom, during the month prior to neurosurgical consultation.

She was obviously terminal. Her demands for relief, the disturbance she set up, taxed everyone, house officers as well as nurses. Medication was as frequent as every two hours. She was too far gone physically to attempt a procedure such as chordotomy.

Under pentothal anesthesia, a bilateral prefrontal lobotomy was carried out on March 6, 1947. Following this procedure the patient, after the usual period of inertia of about four to five days duration, was alert, visited pleasantly with her family. She was affable, quiet and content. Subsequently only 2 grains of luminal and ¼ grain of morphine were required until time of death approximately one month later.[7]

Although it is difficult to predict in each individual case, the balance-sheet of profits and losses, current practice demands that the *gravity* and *incurability* of the mental disease should be taken as criteria for deciding in favour of this intervention [leucotomy]. When the true human personality appears to be buried, in no uncertain fashion, under the action of affective pathological mechanisms, the positive outcome of the intervention will more than compensate for the accompanying losses; for it will be a liberation — modest, indeed, but qualitatively significant — of the power of abstract thought, of the will, and of a certain interior freedom.[8]

[7] Edmund A. Smolik, M.S., M.D., F.A.C.S., "Surgical Methods for the Management of Intractable Pain," *Mississippi Valley Medical Journal and Radiological Review*, Mar., 1948. Quotation from a reprint without page numbers.

[8] *The Ethics of Brain Surgery*, p. 28.

It is essential that we should maintain our perspective and keep the whole picture before us. Here is a psychotic patient, hopeless, irrational, illogical, submerged in a psychotic quagmire. He has a successful leucotomy. He becomes rational, logical and responsible. He works efficiently in an office, in the home, for the council, as the presented cases showed us tonight. Indeed, he once more becomes capable of human acts.

It is true that leucotomy has reduced his capacity to become an Ignatius Loyola, but it has lifted him out of the aimless psychotic impotence. At least he is now capable of intelligently striving to reach the lower storeys within the celestial hierarchy.[9]

4. THE INDIVIDUAL CASE

According to the directive, psychosurgery is morally justifiable when it is medically indicated. This preoperative medical judgment, though especially difficult as regards psychosurgery, is made along essentially the same lines as in other serious surgical procedures. For instance, no competent and conscientious doctors would decide for or against any serious surgery merely on the basis of general statistics and results in other cases. The judgment must be made in terms of the particular patient's condition; the good and bad effects are weighed as they will probably occur in this case; and the final judgment to operate or not operate is concerned with a comparison of these probable effects on the patient. All this may seem too obvious to mention; yet I have seen some literature, both medical and moral, which at least implies that important surgical decisions should be made merely on the basis of statistics. This, of course, is not correct. The doctors' ultimate responsibility must always be con-

[9] *The Transactions* (see footnote 5), p. 41; statement by Dr. F. J. Kyneur.

cerned with the individual case.

Another consideration common to all preoperative decisions concerns the possibility of obtaining the same good effects in some more conservative manner. Thus, in our particular problem, everyone would admit, I think, that the ideal treatment for mental illness and pain is psychotherapy, because psychotherapy is completely constructive. And, when psychotherapy is not feasible, the next consideration must be given to the possibility of producing the good results by means of chemical therapy. In the treatment of pain, this is the more common way of dealing with the situation: that is, by means of drugs, the use of which can be carefully controlled. As I write this chapter, there are already some indications that the use of various forms of chemical therapy may supplant the more drastic measures that have been used in the treatment of mental illness and intractable pain. Even the most enthusiastic supporters of psychosurgery would welcome further progress along these lines.

Physicians and moralists who write about psychosurgery usually stress the idea that it is a procedure "of last resort." This is the meaning of the directive when it says that psychosurgery is not justifiable "when less extreme remedies are reasonably available." Article 41 of the Canadian Code is more specific and more helpful on this point. It states that psychosurgery is permitted "when other treatments have failed, or are unavailable or deemed medically inexpedient."

Theoretically, the choice of therapeutic measures is always made in terms of the best interests of the patient. Other considerations such as the advancement of science and the help of other people are secondary. Every medical society would subscribe to these statements. The directive, in calling attention to the primary place of the patient's welfare, emphasizes the fact that he is a *person*. There are several reasons for this emphasis. It is easy to lose appreciation of the true human dignity of some mentally ill persons; and this can lead to experimentation for the good of others at the expense of the patient. It is my impression that such experimentation is more common in public institutions than in private hospitals and that it is less common in our country than in some others.

Failure to appreciate the personal dignity of the patient can also lead to psychosurgery just to make him more manageable. If this means merely to reduce the work of those who care for him, it is completely unjustifiable. I say "merely," because in some instances it is actually for the patient's own good to make him "more manageable." I refer to cases in which the psychosurgery protects him from himself by reducing a suicidal impulse, and makes it possible for him to have greater liberty by reducing dangerous antisocial traits.

In the human person, there is a hierarchy of values, as Pope Pius XII has pointed out.[10] The high-

[10] Cf. his statement in the concluding section of this chapter.

est value, of course, is spiritual: the power to think and to use free will. No good of the merely corporeal order is sufficient to compensate for the loss of these spiritual powers. Yet, when those treating the mentally ill forget their personal dignity, they may also forget this order of values and sacrifice the spiritual for the corporeal. Thus, we hear at times that patients have been dehumanized, turned into vegetables, by psychosurgery. Very likely such things have happened chiefly because of unintentional mistakes in predicting results or in unintentionally making an operation too extensive. Yet, they can also be the result of a materialistic mentality that does not recognize the true dignity of the human person.

The specialists quoted in the previous section show a fine appreciation of true values. Those who speak of the mentally ill make it clear that their aim is to liberate the spiritual powers. And, though the doctor does not mention the spiritual aspect explicitly, it seems clear that the woman who had the prefrontal lobotomy for pain was better able to prepare herself for death after the operation than she was before. In her case, as in all terminal cases, the ability to pray and to cooperate with grace should be considered as especially precious. In terms of the human person and his destiny, it is the supreme value.

5. CONSULTATION

The Canadian Code explicitly requires the serious consultation of specialists before psychosurgery. Our directive supposes this. Moreover, this is a case in which special care must be taken to protect the interests of the helpless.

6. PERMISSION

Also presupposed here is the necessity of due permission before psychosurgical intervention. If the patient is capable of making his own decisions, he has the inviolable right to give or to refuse consent. To perform the operation through deception or against his will is an invasion of his rights. If he is incapable of making the decision, his parents or guardians have the right to make it for him. Here, too, as I pointed out previously in another chapter, special care to protect the patient is necessary. Hospital authorities should see that no undue influence is brought to bear on the patient or his guardians and that guardians do not make the decision through selfish interests. Competent and conscientious medical consultants can do much to prevent such dangers.

7. THE MORAL DECISION

Granted the conditions explained in the foregoing sections of this chapter, psychosurgery is, as the directive states, morally justifiable. It is hardly necessary to elaborate on this. However, I should like to add a word about a papal statement that has caused some misunderstanding. In his address of Sept. 13, 1952, Pope Pius XII said that a man may not submit to medical procedures which alleviate physical or psychic illness, but at the same time "involve the de-

struction or the diminution to a considerable and lasting extent of freedom — that is to say, of the human personality in its typical and characteristic functions. In that way man is degraded to the level of a purely sensory being — a being of acquired reflexes or a living automoton. Such a reversal of values is not permitted by the natural law."

When that statement first appeared, some doctors asked me whether it was a condemnation of psychosurgery. They were much concerned over that. Actually, there was no sound foundation for such concern. The Pope was simply indicating in rather broad, general terms a case in which the harm to the patient would outweigh the benefit, because no merely material benefit would compensate for the loss of freedom "to a considerable and lasting extent." I think this point was explained sufficiently in section 4 of this chapter.

HEALTH CARE OF EXCEPTIONAL CHILDREN

A Challenge to Catholic Physicians

William F. Jenks, C.SS.R.

THERE is a very definite need for better medical service in Catholic elementary and secondary schools throughout the nation. The responsibility for providing medical and dental care is a family responsibility and school health services merely supplement the health care parents should provide for their children. Enlisting the aid of Catholic organizations does not in any way minimize the responsibility of parents, or our belief that Catholic citizens have a right to health services, transportation, free textbooks and freedom from Federal and State taxes. It does, however, furnish an outlet for charitable experiences by Catholic professional personnel in the line of Christian duty.

The role of physical disability in learning has not been sufficiently recognized. It is estimated that 80 per cent of the school children in the United States who have disabilities are not receiving necessary attention. What provisions are being made in your local parochial schools for the physically or mentally handicapped? Besides sensory deficiencies, there are many limitations imposed on learning because of glandular dysfunction and dietary deficiencies.

Many Catholic educators today fail to realize that chronic illness and fatigue, sensory disorders, "cross dominance" and inadequate diet have a direct effect upon the child's attitude, behavior and ability to learn. Hidden handicaps — such as poor eyesight or poor hearing — may prevent an intelligent child from learning to read or write. These handicaps may be either physical or psychological. When parents or teachers fail to recognize the symptoms, a child is unjustly labeled as mentally retarded, lazy or recalcitrant. Children with major difficulties are receiving better care than those suffering from minor conditions. Unrecognized sensory defects are not only the cause of backwardness in the slow-learning child, but also the core of the delinquent problem.

Both learning problems and disciplinary difficulties have been reduced by proper medical care for defective vision and hearing. Many causative factors in the life of the delinquent child could be removed through the pooling of the resources of our Catholic professional organizations and the cooperation of Catholic fraternal organizations.

A survey conducted by the

United States Office of Education revealed that 93 cities of 100,000 or more population and 87 per cent of the cities under 10,000 population have a school health service. A survey by the American Dental Association found that 87 per cent of the cities of 100,000 or more population have school dental programs, while only 41 per cent of cities under 5,000 reported similar programs. More than 85 per cent of public schools in cities throughout the nation have nursing service.

The health needs of the nation are a long way from being met. The total medical bill for the country exceeds ten billion dollars. There is one dentist for about every 1,800 persons in the country. It is difficult to determine just what the ratio of the physician to the population should be. Many believe that there should be one doctor for every 742 persons. The absolute minimum decided upon for the adequate care of civilian health during World War II was one doctor for 1,500 persons.

There is a tremendous shortage of properly trained psychiatric personnel. More than 15,000 psychiatrists are needed. Only five states have 80 per cent of needed psychiatrists. 35 states do not reach 20 per cent of the standard of psychiatric nurses, and 14,500 more nurses are needed.

There are now more than 55 Catholic Child Guidance Clinics throughout the United States. One of those recently established is on a volunteer basis. In some of the public guidance clinics, there is a waiting period of two or three years before service can be given. $70.00 is spent for each new case of crippling polio yearly, and only $2.00 per victim for each new case of mental deficiency. And yet, mentally ill patients alone occupy more than half of the nation's hospital beds. 120,000 mentally defective children are born each year in the United States.

School health work began in Boston in the year 1894. The war years disclosed great deficiencies and our greatest effort in this field has been since 1915. It is alarming to know that 700,000 men, or 16 per cent of the total number examined by Selective Service, were rejected from the draft because of nervous and mental disorders. Another 582,000 (13.8 per cent) were rejected for other reasons, including mental defects. 45 per cent of those discharged from the army for disability were dropped for psychiatric reasons.

This picture takes on a more alarming front when we realize that 12.7 per cent of our children of school-age are either physically or mentally handicapped, and that one out of every twelve children will one day need psychiatric care.

The Selective Service examinations during and after World War II offer the best nation-wide data we have on the physical status of the male population. It is reported that of the sixteen million youths examined, half were unfit for military service. These consisted of five million rejectees; one and a half million men who were inducted but had to be discharged for mental or physical defects not acquired in the service. Some type

of illness or physical defect was present in eight out of every ten persons examined. During the Korean Police Action, 15 per cent of those examined were totally rejected for medical reasons only. The health of the nation at this time was not improved, but the physical standards for military service had been lowered. The President's Physical Fitness Program today has been sparked by the revelation that the school children in the United States are less healthy than those living in Europe. Probably more than half of the poor physical conditions discovered in our school-age children today could have been prevented with timely care.

Health education must be redefined so that it clearly and completely encompasses the total health of each child — his emotional, moral, social, as well as his intellectual and physical needs. The primary end of school health services is to identify health problems, adjust school programs to the needs of children, inaugurate a program for exceptional children, that is, physically or mentally handicapped children, and make known to parents those children who apparently need medical and/or dental care.

American children in spite of being well fed are not necessarily well nourished. Learning difficulties have been traced to dietary deficiency, especially vitamin deficiency. During the 1954-55 school year, approximately eleven million children participated in the school lunch program and 80 per cent were served Type A lunches. All of our Catholic schools should have the school lunch program and also the school milk program.

A recent survey disclosed that 32 of the 42 state medical associations had committees concerned with the school health program, and 34 per cent of the local medical associations were concerned with school health. School health service activities include complete medical examinations or health appraisals; dental examinations and cleaning of teeth; screening for vision and hearing; conscientious follow-up after medical and dental examinations to assure the correction of any adverse conditions discovered; communicable disease control; first aid in case of emergency; health counseling and guidance, and provision for physically or mentally handicapped children. It is not enough for a child to have a medical examination or dental inspection; he must understand *why*. An understanding of the reason will alert him to seek these services of his own accord when he becomes an adult.

One of the main functions of school health service is that of appraising student health. This is achieved through medical examinations and by various screening procedures. More than 28 states, by law, require periodic health examinations, and in the remaining states, many school systems provide them voluntarily. There are many conflicting opinions on the number of medical examinations which are required in elementary and secondary schools.

The trend today seems to have children examined and given boos-

ter immunizations before they enter school, and then have three or four additional examinations during the child's school life; e.g., at Grade 4; upon entering Junior High (Grade 7); upon entering Senior High School (Grade 10); and finally in the year before graduation from high school. Dental supervision should be given more frequently. The American Dental Association recommends that each child be given an examination by a dentist at least once a year. This examination should be made with mirror and explorer; and when advisable, dental x-rays should be taken. The dental hygienist works with the teacher and the dentist and through her preliminary inspections of teeth and her prophylactic cleansing can be of great service in follow-up procedures. In a questionnaire study by Menczer, it was learned that 67 per cent of the 94 superintendents of public schools in cities of more than 90,000 population endorsed the practice of excusing children during school hours to receive dental care.

Catholic dentists should use every means at their disposal to stop the sale of candy in parochial schools and not allow the children's health to be jeopardized for mercenary profit. The Catholic team of professionals should strongly advocate the installation of the milk-bar; the fruit-bar; the fruit-juice bar, and the warm lunch and vitamin program.

A St. Louis study failed to determine which vision screening device was superior to the others. Cromwell's study definitely substantiates the custom of annual vision screening. Where new parochial schools are being built and old ones renovated, the Catholic team of professionals could advise the Reverend Pastor of the need for a health room which would not only be large enough for the use of the Snellen Chart, but properly fitted and supplied for any emergency. Catholic nurses could instruct the nuns and brothers and lay teachers and also members of the Home and School Association in vision screening procedures. Catholic fraternal organizations could supply glasses to needy children.

Health service programs should provide for regular hearing screening. Portable audiometers are now available. In some states they may be obtained on loan from the Department of Health and Education. Teachers, or parents, could receive special training in conducting audiometric tests and reading and recording the results. A very quiet room — preferably on the top floor — should be used for these tests.

Only 21 states conduct statewide hearing tests in the schools, and only 14 states have laws requiring a hearing test for all children. 4 states provide mobile speech and hearing units. The cause of the difficulties in many slow learners in reading, spelling, arithmetic and handwriting, can often be traced to some minor physical disability which was overlooked or not discovered, such as poor vision or poor hearing. Discovery at the earliest possible moment is of the utmost importance not only to the child but to society.

A major problem in parochial

school circles today is providing for the care and education of the large number of emotionally disturbed children. There is a great need for screening school children for mental and emotional needs and problems, since one out of every twelve children will eventually need psychiatric care. In a study at the University of Florida a significant positive relationship was found between the existence of certain emotional problems and the frequency of somatic illness.

Cumulative health records for each student are an absolute necessity in all Catholic schools. The overcrowded classrooms of parochial schools prevent the care and consideration that should be shown to pupils returning to school after a serious illness.

Large numbers of school children are not protected against diphtheria, tetanus and smallpox. Due to the 80 to 90 per cent effectiveness of the Salk vaccine, poliomyelitis vaccination should become routine. Discovering conditions which require professional attention is futile unless a practical follow-through program is planned. Only 44 per cent of the public schools in cities have such a follow-through program.

Children with physical or mental handicapping conditions — so-called exceptional children, which is an umbrella-like term that includes all deviates, from the idiot to the gifted — should be placed in the same school building with the so-called normal children. Special classes should be provided for the educable mentally retarded children with an approximate I Q of 50-75, while the trainable children with an I Q below 50 should be placed in a nursery under the care of the Catholic Charities with a teacher trained and appointed by the Catholic schools superintendent. Sheltered workshops for this group should be established by the St. Vincent de Paul Salvage Bureau. A complete listing of all residential and day schools; clinics and facilities for more than a million and a half Catholic exceptional children, that is, children who are either physically or mentally handicapped, emotionally disturbed or socially maladjusted, is published in the *Directory of Catholic Facilities for Exceptional Children in the United States,* published by the Special Education Department of the National Catholic Educational Association, 1785 Massachusetss Ave., N.W., Washington 6, D. C. ($1.75).

With professional advice from members of the Catholic team of physicians, dentists and nurses, parochial school administrators should welcome physically or mentally handicapped children and open their doors to them, so that they might be taught the truths of our holy Faith. Epileptics with infrequent seizures, cardiacs, children with rheumatic heart conditions, cerebral palsied children and the like should not be deprived of religious training in parochial schools simply because of their handicaps. The professional team made up of these outstanding Catholic men and women could convince the Reverend Pastor and his school principal that a withered hand or leg does not mean a

crippled brain, and allowance should be made for individual differences. God has willed these physical or mental defects and consequently these children should not be discriminated against because of some physical or mental disability.

Three very fine Catholic organizations exist in the United States today — the Federation of Catholic Physicians' Guilds, the groups totaling 71 in 31 states; the Apollonia Guilds of Catholic Dentists, 9 in 6 states, and the National Council of Catholic Nurses with 97 diocesan councils, numbering about 20,000 members. If these organizations were to join forces under the direction of the superintendent of their diocesan schools and supplement the meager offerings in the field of health services in parochial, elementary and secondary schools, Catholic institutions would report better scholastic results in schoolwork and would graduate healthier students. We are advised that in some areas of the country, the Catholic Physicians' Guilds have taken on as a continuing project the physical examinations of school children. This is a good beginning and more are encouraged to participate in these health efforts. An active team could mean that each physician need give only a few hours a week of his valuable time for this worthy cause and merit the appreciation of the grateful community in which he lives.

Father Jenks is Associate Secretary in charge of Special Education, National Catholic Educational Association, Washington, D. C.

ARE CATHOLIC PHYSICIANS ADOPTING A NEGATIVE ATTITUDE TO A VITAL SOCIAL PROBLEM?

John Ryan, M.B., B.S., F.R.C.S., F.I.C.S.

Dr. Ryan, a visitor to the United States from England, in the summer of 1957, observed hospitals and the practice of medicine in many areas of the country. Following are some of his observations.

An article appearing in the *Eugenics Quarterly,* March 1956, written by Father William J. Gibbons, S.J.[1] once more gives definite guidance to Catholic physicians on medico-moral problems in marriage, particularly those associated with fertility. For those who wish to study more fully the justification of the Church's teaching on the subject, the article is accompanied by an excellent bibliography.

There has been a spate of literture in the last few years regarding the Catholic point of view on marriage, with particular emphasis on the moral aspects. As a result of this, the public has become increasingly interested not only in the medical and social aspects of fertility, but also in the influence of past and present religious teaching on this subject.

Many may think, as I do, that whereas the moral issues have been clearly defined, the medical issues are somewhat obscure; mainly because the Catholic medical approach has been all too negative. The real question we must ask ourselves as Catholic physicians is whether or not we are adopting a negative medical attitude to a vital social problem. Secondly, whether we are making the most of our opportunities to present to our non-Catholic colleagues facts and figures resulting from investigation of the problems of fertility, such studies having been conducted in accordance with our moral principles. In brief, can we submit scientific data to support our view that, not only is our approach, both in the field of research and treatment, morally correct, but also equally sound medically?

In order to present this picture, we must have the same facilities for research and team-work as our non-Catholic colleagues. There would appear to be a need for constant encouragement in Catholic medical schools to impress upon students the importance of research; a fact that has been referred to in a report on medical

[1] "Fertility Control in the Light of Some Recent Catholic Statements," *Eugenics Quarterly,* March 1956, Vol. 3, No. 1.

education and research in American Catholic medical schools and hospitals.[2]

In the United Kingdom medical research under the auspices of a Catholic hospital in the field of fertility is almost impossible. Catholic hospitals are few and far between. None has the status of a teaching hospital; they all work under the voluntary system with no State support and they are relatively small—the most prominent Catholic hospital in London has only 200 beds. Its out-patient department is antiquated; its staff is very small, and no research of any sort is pursued.

In the United States, on the other hand, there appear to be definite possibilities. I understand that some 1,141 Catholic hospitals are included in a national total of 6,970, and that there are six four-year Catholic medical schools.

Recently, I had the pleasure of visiting the United States and seeing for myself some of the magnificent Catholic hospitals and learning of plans to construct others. I had the pleasure of meeting many staff members and retain most happy memories of the hospitality and welcome extended to me. I was deeply impressed by the determination and keenness of these men to ensure these hospitals attaining a standard of work second to none. Nevertheless, I was reminded frequently that there are still many problems to overcome, particularly relating to extension in the field of research, generally. I was surprised that it was so difficult to find a Catholic clinic attached to any hospital, dealing extensively with the problems of fertility and physical maladjustments of married life. I had envisaged a research clinic on problems such as fertility consisting of a team composed of at least the following: an obstetrician, a gynecologist, a genito-urinary surgeon, an endocrinologist, a psychiatrist, a biochemist, a radiologist, a general physician, and specialized auxiliary workers.

I was left with the impression that there is in the United States, as in the United Kingdom and Europe, a prejudice against the establishment of Catholic fertility clinics, prevailing particularly with some of the clergy who seem to associate this type of work and research exclusively with birth control and planned parenthood. No doubt, a limited amount of activity in the clinic would be concerned with advice on family spacing when considered necessary. It does not seem to be realized, however, in Catholic circles, that both in the United States and in the United Kingdom one out of ten marriages is involuntarily sterile and that sterility is a problem of great magnitude offering an immense field of research. As Catholics, we stress, perhaps sometimes unduly, the primary object of marriage — reproduction — and therefore, one would expect that the Catholic medical profession would lead the way in research on this

[2] *Medical Education and Research in Catholic Medical Schools and Hospitals: Report of a Special Study* by John J. Butler, M.D. and Edna M. O'Hern, Ph.D. (The Catholic Hospital Association of the United States and Canada, St. Louis 4, Missouri.)

subject. I feel very strongly that team-work is a *must* in any research on this subject, even though, as I observed in America, there have been many valuable contributions by individual physicians which might well, with advantage, be co-related under one roof.

I am not suggesting that if a Catholic couple that is sterile were to attend a general clinic in the United States or in the United Kingdom, there would be an enforced examination which would be against their moral principles or advice would be given contrary to their moral beliefs, but I do suggest that if they are placed in the position of having to refuse to undergo certain tests or accept specific advice, they may believe that the investigation of their problem is thereby incomplete. This, of course, can be proved otherwise, but only if they can attend alternative clinics where proof can be shown. The absence of a Catholic clinic has fostered a state of mind, not uncommon in the United Kingdom, which predisposes Catholics to believe that because they are Catholics, their problem cannot be fully investigated. This state of mind may well exist in the United States also.

The approach to medicine as a science can never be denominational; it is against its very essence. It cannot be merely nation-wide; it can only be international. Nevertheless, until the medical profession and the public have the same concept on moral issues relevant to marriage, there will be a necessity for Catholic clinics to deal with marriage problems in their medico-moral aspects.

The non-Catholic doctor, as I pointed out in *Marriage*[3], is not a metaphysician nor a moral theologian, and if you want to convince him, you must give him facts. It is little use arguing with him *a priori*, for he is trained and conditioned to judge by objective evidence.

In a world where there is a tendency to put science in the place of God, there is an urgent necessity for the Catholic medical profession to unite and prove that good morals make good medicine and to deflate the popular conception that the practice of Catholic medicine is second rate because of the moral restrictions placed upon its physicians.

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[3] *Marriage: A Medical and Sacramental Study*, Alan Keenan, O.F.M. and John Ryan, M.B., B.S., F.R.C.S., F.I.C.S., p. 8. (Sheed & Ward, New York, 1956.)

Book Review

Modern Miraculous Cures

Francois Leuret, M.D. and Henri Bon, M.D.

(Translated by A. T. MacQueen, M.D. and Rev. John C. Barry)

Review by

NORMAN M. MACNEILL, M.D.

This seems unquestionably the best medical treatise on miraculous cures written up to the present time; and, if most of the cases reported are from the Lourdes' Shrine, it is because Doctor Leurent is former president of the Medical Bureau and Scientific Studies at Lourdes. His co-author, Doctor Henri Bon, is a noted contributor to French medical literature.

By happy chance, this book, as well as the outstanding one on Lourdes by the late Ruth Cranston, a non-Catholic, appears on the eve of the centenary celebration of the Lourdes' apparitions in 1858, a phenomenon which more and more, as time passes, seems to have been the providential antidote to the misapplication by materialist and determinist nineteenth century biologists of the evolutionary theory of man, sparked by Darwin's "Origin of Species," published one year later (1859).

The translators have succeeded admirably in avoiding the "bugs" and translational nuances which so often mar medical translation into English.

The many case histories of miraculous cures are well and technically described. Chapter X, regarding the etiology and physiology of miraculous cures, deals at length with the method by which the diagnosis of a miraculous cure is arrived at, both, from the scientific as well as the theological point of view: as an earlier chapter explains, the Church's procedure in the investigation of the cures. Examples are also given of false cures.

The book presents a fascinating technical study of its subject and suggests that "The examination of great — we may say, classical — miracles has helped to show that the study of miracles demands that we raise and broaden our views beyond their present anthropomorphic limits and rise above the level of the sort of laws laid down dogmatically by the nineteenth century scientists, which are now out of date."

Physicians, medical students and nurses will enjoy this book and profit by it. It should find a place in every medical and college library.

Its factual descriptions of occurring phenomena, which are as often misrepresented as they are misunderstood make it an invaluable adjunct to our necessarily imperfect understanding of the miraculous.

Modern Miraculous Cures
Published by
Farrar, Straus and Cudahy
215 pages
$3.50

MINUTES OF THE DECEMBER MEETING — 1957

THE FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

The December meeting of the Executive Board of The Federation of Catholic Physicians' Guilds was held in Philadelphia, Pennsylvania, December 7-8, 1957, at the Adelphia Hotel. The following were present:

Officers

W. J. Egan, M.D. — President
E. J. Murphy, M.D. — First Vice-President
J. E. Holoubek, M.D. — Second Vice-President
C. P. Cunnningham, M.D. — Third Vice-President
J. J. Graff, M.D. — Secretary

Others

Rt. Rev. Msgr. D. A. McGowan — Moderator
Rev. J. J. Flanagan, S.J. — Editor, THE LINACRE QUARTERLY
D. A. Mulvihill, M.D. — Honorary President
J. J. Toland, Jr., M.D. — Past President
Wm. P. Chester, M.D. — Past President
M. F. Yeip, M.D. — Past President
Mr. M. R. Kneifl — Executive Secretary
Miss Jean Read — Assistant Secretary

Affiliated Guilds represented

Alice Holoubek, M.D. — Shreveport, La.
Charles Crawley, M.D. — Brooklyn, N. Y.
Rev. James H. Fitzpatrick — Brooklyn and Queens, N. Y.
G. Griffin, M.D. — Brooklyn, N. Y.
J. J. Coletti, M.D. — Rockville Centre, N. Y.
D. J. Bradley, M.D. — Rockville Centre, N. Y.
Geo. Price, M.D. — Brooklyn, N. Y.
N. M. Macneill, M.D. — Philadelphia, Pa. (Rene Goupil)
J. M. Gambescia, M.D. — Philadelphia, Pa. (St. Francis of Assisi)
T. J. English, M.D. — Philadelphia, Pa. (St. Francis of Assisi)
Rev. N. J. Curran — Philadelphia, Pa. (St. Francis of Assisi)
Rev. Michael Walsh, S.J. — Boston, Mass.
Robt. Eiben, M.D. — Cleveland, Ohio
Very Rev. Msgr. F. W. Carney — Cleveland, Ohio
J. J. Muccigrosso, M.D. — Westchester, N. Y.
J. I. Porter, M.D. — Stamford, Conn.
F. E. Darrow, M.D. — Oklahoma City, Okla.
Fred M. Taylor, M.D. — Houston, Texas
E. J. Murphy, M. D. — Bronx, N. Y.
Wm. P. Chester, M.D. — Detroit, Mich.
D. A. Mulvihill, M.D. — New York, N. Y.
J. J. Graff, M.D. — Wilmington, Del.
C. P. Cunningham, M.D. — Rock Island, Ill.
B. R. Marger, M.D. — Allentown, Pa. (prospective Guild)

The meeting was called to order at 9:30 a.m. with prayer by Very Rev. Msgr. F. W. Carney, Moderator of the Cleveland Guild.

After roll call, the president requested vote on the minutes of the Executive Board Meeting, June 4, 1957, in New York, N. Y. as mailed by the central office, dispensing with the reading thereof. Approved as mailed.

President's Report

As his first report, Dr. William J. Egan of the Boston Guild, elected to the presidency at the June 1957 executive board meeting, advised of his efforts to promote the organization of new Guilds throughout New England, contacting the Bishops of the various dioceses.

Announcement was made of committees to assist with the activities of the Federation. Members are as follows:

CONSTITUTION

Rev. Ignatius W. Cox, S.J.
Fordham University
Bronx 58, New York

Rev. Michael Walsh, S.J.
Boston College
Newton, Mass.

David Conway, M.D.
New Haven Guild
New Haven, Conn.

Eusebius J. Murphy, M.D., Chairman
Bronx Guild
Bronx, N. Y.

William P. Chester, M.D.
Detroit Guild
Detroit, Mich.

A. M. Alexander, Jr., M.D.
Alexandria Guild
Alexandria, La.

MEMBERSHIP

Rt. Rev. Msgr. D. A. McGowan
Washington, D. C.

Jeff J. Coletti, M.D.
Rockville Centre Guild
Old Westbury, L. I., N. Y.

A. J. Wallingford, M.D.
Albany Guild
Albany, N. Y.

C. P. Cunningham, M.D., Chairman
Rock Island Guild
Rock Island, Ill.

P. J. Corrigan, M.D.
Cleveland Guild
Cleveland, Ohio

D. T. Hughson, M.D.
Milwaukee Guild
Milwaukee, Wisc.

EXHIBIT

Gerard Griffin, M.D., Chairman
Brooklyn Guild
Brooklyn, New York

Wm. R. Molony, Sr., M.D.
Los Angeles Guild
Los Angeles, Calif.

C. C. Wright, M.D.
Sacramento Guild
Sacramento, Calif.

Thomas J. Fox, M.D.
Portland Guild
Portland, Oregon

B. J. Hoeflich, M.D.
Eugene Guild
Eugene, Oregon

LINACRE QUARTERLY

Rev. J. J. Flanagan, S.J.
Editor
St. Louis, Mo.

J. G. Muccigrosso, M.D., Chairman
Westchester Guild
Yonkers, N. Y.

J. J. Toland, Jr., M.D.
Philadelphia (Rene Goupil) Guild
Philadelphia, Pa.

Rev. J. J. Lynch, S.J.
Weston College
Weston, Mass.

N. F. Thiberge, M.D.
New Orleans Guild
New Orleans, La.

D. A. Mulvihill, M.D.
New York Guild
New York, N. Y.

PROJECTS

Very Rev. Msgr. F. W. Carney
Moderator, Cleveland Guild
Cleveland, Ohio

J. E. Holoubek, M.D., Chairman
Shreveport Guild
Shreveport, La.

T. J. Greteman, M.D.
Dubuque Guild
Dubuque, Iowa

J. W. James, M.D.
Saginaw Guild
Saginaw, Mich.

R. M. Eiben, M.D.
Cleveland Guild
Cleveland, Ohio

MEDICAL SCHOLARSHIPS

Rev. Austin E. Miller, S.J.
Creighton University
Omaha, Nebr.

J. J. Graff, M.D., Chairman
Wilmington Guild
Wilmington, Dela.

M. F. Yeip, M.D.
Cleveland Guild
Cleveland, Ohio

L. D. Cassidy, M.D.
St. Louis Guild
St. Louis, Mo.

N. M. Macneill, M.D.
Philadelphia (Rene Goupil) Guild
Philadelphia, Penna.

Report of the Moderator

Report was made of new Guilds in process — Toledo, Ohio; Trenton, N. J.; Ogdensburg, N. Y.

Comment made on the Silver Jubilee celebration of the Federation — the Mass at St. Patrick's Cathedral and the banquet at the Waldorf-Astoria Hotel.

The "White Mass" to honor St. Luke on October 18 (special report prepared) mentioned as the outstanding spiritual activity of the Federation and constituent Guilds.

Monsignor McGowan explained the 1st Catholic World Health Conference to be held in Brussels, July 27-August 3, 1958, at the same time as the World Exhibition. Those who will participate in the Conference will be: VIIIth Congress of the International Association of Catholic Physicians; VIth Congress of the Catholic International Committee of Nurses and Medical Welfare Workers; Vth Congress of the International Federation of Catholic Pharmacists, and 1st Congress of the International Federation of Catholic Hospitals. Germany's Chancellor Adenauer is to be a principal speaker. Pilgrimages are being sponsored. It is the 100th Anniversary of Lourdes. Msgr. McGowan was authorized to represent the Federation at this Conference. All Catholic physicians attending are to be designated as delegates from the Federation.

It was advised that the Guild of Catholic Psychiatrists is interested in membership in the Federation. Since the group has its own organization, it was deemed best to invite a representative to attend a future Executive Board meeting for discussion of the matter. The concensus of opinion was that members of that Guild join their own local physicians' groups and have the privilege of sending a delegate from their own organization to the Federation Board meetings as an associate organization. The president was advised to appoint a committee to consult with a spokesman of the group, inviting him to attend the next Executive Board meeting.

Fee for membership in the International Federation of Catholic Physicians' was stated to be based per capita or a total of some $266.00, payable to the International Secretary.

THE LINACRE QUARTERLY

Report of subscriptions indicated the November 1957 issue mailing to be 8,970. 4,603 copies reach members of Catholic Physicians' Guilds. To increase subscriptions, advertising in selected journals was authorized.

Editorial-wise, it was reported that more medical articles are needed. It was suggested to contact the deans of medical schools for articles. To stimulate interest, it was suggested that each Guild appoint a member to be responsible for sending material to the Editorial Board for publication consideration.

The matter of acceptable advertising is to be left to the discretion of the Editorial Board.

Membership Report

It was reported that 69 Guilds now comprise the Federation with a membership of 4,603. The Membership Committee chairman reported that the aim is to

establish Guilds throughout their own diocese and neighboring ones. An eventual aim is to promote diocesan meetings of presidents and moderators.

Representatives reported on local efforts. Brooklyn advised that county groups are being established. In Houston, physicians within a radius of many miles are contacted. In Louisiana, all Catholic physicians in the state are contacted. The Boston Guild is organizing subsidiary branches; interns and residents in hospitals are invited to join without payment of dues. Philadelphia is organizing smaller groups. The Bronx Guild sponsors other Guilds. Report on the situation in Chicago is to the effect that small groups are functioning as Guilds that may never join an organized society, preferring complete autonomy in their activities.

Two ways to organize were set forth:

1. The Bishop of the diocese originates the movement.
2. Interested physicians develop active enthusiasm and then contact their Bishop for permission to organize.

Federation Exhibit

During the American Medical Association Convention to be held in San Francisco June 23-27, 1958, the Federation will again sponsor an exhibit. Dr. Gerard Griffin, chairman of the Exhibit Committee, advised that assistance would be forthcoming from members. Guilds on the west coast will be asked to take responsibility for a day at the booth. Literature will be available for distribution and Physician Guild members will be present to talk with visitors.

The chairman asked that Guilds advise him of any members planning to attend the A.M.A. convention in San Francisco.

Report of Silver Jubilee Celebration

Dr. D. A. Mulvihill, chairman of the Federation Silver Jubilee celebration, reported details of the occasion. He advised that with funds borrowed from the Federation general treasury and the Guilds in New York, 7500 invitations and 1085 letters of solicitation were mailed. A volunteer corps gave great assistance. Pharmaceutical houses gave donations amounting to $7,000.

Pharmacy houses gave substantial donations. The C.H.A. and 203 member hospitals responded generously. Five Guilds were patrons. Cash gifts amounted to nearly $16,000. There were 1,496 guests at the banquet.

Gratitude was expressed to Dr. Mulvihill and others of the committee present — Drs. Murphy, Muccigrosso, and Griffin — for their tremendous effort to make the celebration the success it was. A word of praise was also accorded the wives of the doctors who were also very helpful.

The day's business drew to a close with prayers for the committee and their wives, proffered by Father Fitzpatrick.

* * * *

The meeting on Sunday, December 8, began at 10:00 a.m.

The "White Mass"

Special report of the "White Mass" observance to honor St. Luke, October 18, has been prepared and distributed relating the activities in many localities for the occasion. The establishment of the annual "White Mass" throughout the country was acknowledged the Federation's most important function.

Annual Meeting — Federation Executive Board

The annual meeting of the Federation Executive Board will be held Wednesday, June 25, in San Francisco. Representatives will assist at Mass offered for deceased members of the Federation, followed by the meeting. An afternoon reception will take place at 4:30, for all Catholic physicians attending the A.M.A. convention.

Winter Board Meeting, 1958

It was voted to hold the winter Executive Board meeting, December 6 and 7, in Milwaukee, Wisconsin.

To encourage Guilds to send a delegate to Board meetings, the president was asked to write the groups urging that they defray the expenses of members who will give the time to attend.

Reports of Committees

Projects

The following project suggestions were made:

1. That each Guild sponsor an annual retreat.
2. That the June Executive Board meeting always include Mass for deceased members.
3. That more Guild publicity be initiated locally to acquaint individual communities with these organizations.

4. That the "White Mass" be promoted in every area of the country.
5. To promote Medical School Student Guilds.

(Mr. William Gordon, a senior at Temple University, addressed the Board advising the needs of Catholic students. They often have no answers to their problems. The doctor-student relationship is not close as too few doctors devote time and effort to working with these groups. The enthusiasm of the organizations varies. To stabilize them and encourage attendance, well-prepared speakers are needed. It is felt that through such student organizations, habits of Catholic Action will be formed and provide deeper spiritual motivation. If strong student groups are formed, those same members will be encouraged to form Catholic Physicians' Guilds later. It was mentioned that in Philadelphia there are five student groups and it is hoped a national organization will eventually develop. Women's Medical College reported an active group, receiving excellent assistance from Catholic members of the faculty.

The activities of the student medical groups in non-Catholic universities in Boston were explained by Father Michael Walsh, S.J., moderator of the groups. He advised of monthly meetings with joint sessions; non-Catholic students also attend. The president of the group should be the leader; the interest of others is measured by his own. Needs of respective groups must be met; topics of interest to seniors do not necessarily encourage first-year students to attend sessions.)

Guilds in areas where there are medical schools will be urged to cooperate with these student groups, assisting with meetings and solving problems.

Medical Scholarships

Pending investigation of existing funds available, the promotion of medical scholarships through the Federation will be held in abeyance.

THE LINACRE QUARTERLY

Guild members are to be urged to write for the Federation journal. Articles concerning teaching and research problems desired; those of historical nature are acceptable; articles on timely subjects, e.g., antibiotics, would be of interest.

Constitution

Proposed changes to amend the constitution and by-laws of the Federation of Catholic Physicians' Guilds were read and discussed. Same will be prepared and mailed to all Guild presidents for consideration before final adoption at the June Executive Board meeting.

It was moved that the president appoint a Finance Committee to devise ways and means to defray expenses of the Federation for various projects, e.g., A.M.A. Exhibit expenses, etc. It was proposed to add an article to the constitution authorizing a per capita assessment to each Guild's annual dues.

New Business

As a further project, Dr. A. Gambescia of St. Agnes Hospital, Philadelphia, urged missionary vision to follow the Federation's first twenty-five years of organization and focus on medical education. It was proposed that the Federation form a council or conference whose prime work will be to raise the standards of medical education and the medical profession as a whole.

Meeting adjourned

2:30 p.m.

REPORT ON THE "WHITE MASS"
1957

Reports were received at the central office after October 18, the Feast of St. Luke, regarding observance of the "White Mass" in many areas of the country. Hospitals were most cooperative in the observance in many cities where there are no Guilds. An impressive number of the Masses were celebrated by the Bishops of the respective dioceses. The programs of many followed the plan of the Shreveport, Louisiana Guild, about which all groups were informed.

Guilds sponsoring the "White Mass" sent us the following reports:

ALBANY, NEW YORK

The first annual White Mass of the newly organized Guild of St. Luke of the diocese of Albany was celebrated on Sunday, Oct. 20, at 4:30 p. m. The Most Reverend Edward J. Maginn, D.D., Auxiliary Bishop, was celebrant and also preached the sermon. A large attendance included doctors and their families. Sisters, nurses, and student nurses in uniform were also present. Dinner for 350 followed.

To give greater prominence to the observance of St. Luke's Day, at the request of the Albany Guild, Governor Averell Harriman proclaimed October 18 as "Physicians' Day" throughout the State of New York. His Proclamation reads as follows:

> All of us are greatly beholden to the knowledge, skills, devotion, and human understanding of our physicians.
>
> Since time immemorial, the art of healing has ranked with the highest of callings. Down the ages, we have made almost incredible advances in medical science. Today, thanks to the marvelous discoveries of scientific research, our physicians are equipped as never before to fight and to prevent the ravages of pestilence and disease, and are getting more tools of knowledge every day.
>
> In our country, we have virtually eradicated many diseases that were terrible scourges not many years ago. As a result of medical science and the application of that science by increasingly skilled physicians, the average life expectancy of our people goes up each year.
>
> The feast of the Evangelist Saint Luke of Antioch, patron saint of physicians, occurs on October 18, which is a fitting time for us to pay tribute to the medical profession that serves us so well.
>
> NOW, THEREFORE, I, Averell Harriman, Governor of the State of New York, do hereby proclaim October 18, 1957, as
>
> PHYSICIANS' DAY
>
> in the State of New York, and call upon our people to join in all appropriate observance of the occasion.
>
> GIVEN under my hand and the Privy Seal of the State at the Capitol in the City of Albany this first day of October in the year of Our Lord one thousand nine hundred and fifty-seven.
>
> Averell Harriman

BOSTON, MASSACHUSETTS

The fourth celebration in the Archdiocese of Boston under the auspices of the Guild of St. Luke was the solemn votive Mass of the Holy Spirit on Saturday, October 18, at 10:00 a.m. in the Church of St. Ignatius, Chestnut Hill, Massachusetts. Rev. James W. Coyle, chaplain of the Catholic Association of Practical Nurses, was the celebrant and The Most Reverend Eric F. MacKenzie, D.D., Auxiliary Bishop of Boston, gave the address.

CLEVELAND, OHIO

Catholic doctors, dentists, nurses and hospital personnel participated in the annual celebration of the Feast of St. Luke at the White Mass offered at St. John Cathedral, 9:00 a.m. Auxiliary Bishop John J. Krol was celebrant and Msgr. Thomas C. Corrigan, director of the Catholic Youth Organization, delivered the sermon. The

Cleveland Diocesan Council of Catholic Nurses co-sponsored the Mass with the Catholic Physicians' and Dentists' Guild, and members as well as students attended in uniform.

DUBUQUE, IOWA

His Excellency, The Most Reverend Leo Binz, Archbishop of Dubuque, was celebrant of the White Mass, observed Sunday, October 13, at Mercy Hospital Chapel, Cedar Rapids, Iowa, at 10:00 a.m. The sermon was preached by Rt. Rev. Msgr. Maurice S. Sheehy, pastor of Immaculate Conception Church in that city. The Mass was followed by brunch at the hospital. After a Guild business meeting, a tour of the hospital's cobalt radiation center was conducted.

DETROIT, MICHIGAN

The White Mass sponsored by the Detroit Guild was offered at Providence Hospital at 8:00 a.m. on October 18. Father Kenneth P. MacKinnon, the moderator, was celebrant. In the evening Detroit doctors assembled at radio station WJLB to recite the Radio Rosary at 7:15 p.m.

EUGENE, OREGON

The White Mass was celebrated on October 26. Doctors and dentists assisted. Rev. T. L. O'Brien, S.J., guest speaker, addressed the group on the responsibilities of the profession.

NORTH CENTRAL (GREAT FALLS), MONTANA

Invitation to attend the White Mass on October 18 at 8:00 a.m., Columbus Hospital Chapel, was extended to all Catholic doctors, dentists, nurses, and others in the health field. Rev. John Michelotti, doctor of Canon Law, was celebrant and addressed the group at breakfast.

MOBILE, ALABAMA

Sunday, October 20, at 9:00 a.m. the Mobile Catholic Physicians' Guild and the Mobile Chapter, National Council of Catholic Nurses, observed their White Mass. Auxiliary Bishop Joseph A. Durick, D.D., was celebrant and the sermon was given by Rev. Donal Forrester, C.S.P.

NEW ORLEANS, LOUISIANA

The annual White Mass sponsored by the Catholic Physicians' Guild of New Orleans was held at 6:30 p.m., Friday, Oct. 18, in St. Joseph's Church. Archbishop Joseph F. Rummel offered the Mass and Rev. Preston Murphy, C.M., gave the sermon. For the first year, invitation was extended beyond Guild membership. Some 3,000 doctors, dentists, internes, medical students, nurses, pharmacists, laboratory and x-ray technicians, and others, both Catholic and non-Catholic were invited. A reception followed.

PHILADELPHIA, PA. (St. Rene Goupil Guild)

450 invitations were mailed to the Catholic doctors in the Philadelphia Archdiocese to asist at the White Mass celebrated at St. John's Church, Sunday, Oct. 20, 5:00 p.m. Rev. Laurence A. Maher was celebrant and Rev. James J. Harley delivered the sermon. Again, as elsewhere, nurses in uniform and the Sisters added to the impressive gathering of a capacity attendance.

QUEENS COUNTY, NEW YORK

The Guild held its White Mass in the Mary Immaculate Hospital chapel on October 18. The hospital reported concerning the excellent interest and increased attendance over previous years.

ST. LOUIS, MISSOURI

As occurred last year, members of the St. Louis Guild and other hospital personnel observed the White Mass on October 18 in four Catholic hospital chapels at 8:00 a.m. — DePaul, St. Anthony's, Incarnate Word, and Firmin Desloge. At St. Mary's the Mass was offered on Wednesday, the 16th.

SAGINAW, MICHIGAN

At 8:00 a.m. His Excellency Most Reverend Stephen Woznicki celebrated the White Mass at St. Mary's Hospital for the Saginaw Guild. Guest speaker at the breakfast following was Rev. David C. Bayne, S.J., Dean of the Law School, University of Detroit. His subject was "Medical Legal Problems."

SHREVEPORT, LOUISIANA

Following the plan of last year, the Shreveport Guild offered its White Mass at St. John's Church on Sunday, Oct. 20, at 5:45 p.m. Families and friends of the members were invited to participate and to attend the reception which followed. Many groups followed the plan of this Guild in setting up their program for the White Mass observance.

SIOUX FALLS, SOUTH DAKOTA

Mass in the McKennan Hospital chapel at 6:05 a.m. to honor St. Luke was offered by His Excellency The Most Reverend Lambert A. Hoch. Breakfast and a meeting followed.

STAMFORD, CONNECTICUT

His Excellency, The Most Reverend Lawrence J. Shehan, D.D., Bishop of Bridgeport, offered the White Mass for the Cosmas and Damian Guild at 5:30 p.m. in St. John's Church. All hospital personnel from the greater Stamford area were invited and the Sisters from St. Joseph's Hospital, in St. John's parish, attended.

* * * *

There is no Physicians' Guild in Toledo but at Mercy Hospital there is held a Spiritual Conference for Doctors. The White Mass to honor St. Luke was observed at 10:00 a.m. on Oct. 20. At 11:00 o'clock there was breakfast; the Most Reverend George J. Rehring, S.T.D., Bishop of Toledo, attended this year as guest of the doctors. Msgr. Rober A. Maher, spoke appropriately concerning the occasion. Rev. Alfred M. Murphy of the Archdiocese of New York, a practicing physician before his ordination to the Priesthood, conducted the spiritual conference.

The Catholic Physicians' Guild of Steubenville, Ohio (not affiliated with the Federation) observed its first White Mass in Gill Memorial Hospital in that city. Bishop John K. Mussio offered the Mass and addressed the Guild members at a Communion breakfast which followed.

The staff of St. James Mercy Hospital, Hornell, New York observed the White Mass in the hospital chapel on October 18. At the breakfast following the Sister Administrator presented each doctor with a set of the *Medico-Moral Problems* series of booklets by Father Gerald Kelly, S.J.

Roll Call

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The listing below gives the name of the president and moderator of each Catholic Physicians' Guild affiliated with the Federation. These groups constitute the national organization.

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